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research article

Nursing in Uganda: My Summer of Unexpected Discoveries

—Emily Roberts (Edited by Kristin Brodeur)

“How are you, *Muzungu*?” (meaning “How are you, white person?”), my Ugandan co-workers muttered as they carried me out of the operating room. I had been observing an infant’s abdominal surgery when I started to sweat and felt my vision narrow. “People always say this indicates fainting,” I had thought to myself. “But that won’t happen to me, I am an experienced nursing student. The sight of blood and organs doesn’t bother *me*.” Yet faint I did, directly onto the operating table. Did I mention this was my first day?

It was a memorable way to begin my ten weeks in the Pallisa district of Eastern Uganda in the summer of 2007. My bike ride to All Saints Buchanagandi Health Center where I worked six days a week provided a stunning setting: a red dirt road lined with green fields of sorghum, banana trees, maize, millet, cassava, and ground nuts. I rode four kilometers each way on my red bicycle passing three schools, people working in the fields, a cotton ginnery, and a trade center, all to the tune of the Ugandans’ sing-song voices greeting me in the local language, Lugwere.



The author on her daily ride along Mbale–Pallisa Road

Armed with an International Research Opportunities Program (IROP) grant from the University of New Hampshire, I spent the summer exploring the nurse’s role in a rural health center, how education affects her ability to carry out that role, and how her specific duties influence overall job satisfaction. As a third-year American nursing student also studying international affairs, I arrived on site with expectations and assumptions that were turned upside down in a matter of days. I anticipated poverty and possibly anti-American sentiment. I expected to be constantly conscious of my safety. I thought weeks would fly by and I would barely have time to conduct research.

Instead, I was greeted with incredible warmth by the local people and health center staff. I lived with a family that had me peeling potatoes and called me daughter, or *namurocho*, by the end of the first week. People were oblivious to American relations with Uganda, and, if anything, adored America and asked me to take them home with me. I felt safe and secure and lucky to have such a rich cultural experience.

The most unexpected thing may have been that I was extremely lonely at times. Since I did not go to Uganda with other students, I had no one with whom to share new experiences and discuss this radically different culture. I filled my time between large family meals and home-related chores with an intense clinical learning

experience at the health center. I went to Uganda to do research and learn about nursing in this unique environment. Much to my surprise, I lost the role of an American student researcher and became a nurse.

Setting the Scene: Sub-Saharan Africa

With a population of approximately 30 million, an additional 1.4 million internally displaced persons, and at least 200,000 refugees from neighboring countries, the Republic of Uganda is considered one of the world's least developed countries (United Nations Office, 2008). This means that by UN standards, the country has extremely low human and economic development. Despite recent advancements in education, literacy, water quality and availability, and health issues such as HIV/AIDS, Uganda is rife with disease and poverty. There is a general distrust of governmental institutions including hospitals. This means the population does not make use of the few healthcare options available, thereby increasing deaths caused by preventable diseases such as diarrhea and malaria (World Fact Book, 2006). In Uganda, there are both private and government health centers. Treatment is free at government health centers, but problems with resource distribution lead most of the population to seek out private, costly healthcare.

I conducted my research at a private rural health center. The eleven person staff is limited to nurses, midwives, nurse assistants, and laboratory technicians. The health center has inpatient and outpatient services as well as some degree of laboratory and surgical capabilities. The health center serves a sub-county with a population of approximately 21,000 people and has an annual budget of approximately \$7,000. In 2006–2007, they saw over 8,000 patients; 55% of those were treated for malaria.

I conducted ethnographic research through interviews, field notes, and direct experience as a staff nurse. I gathered volumes of data detailing the education of nurses, actual work loads, resource issues, needs of the health center, needs of the nursing population, and the differences between rural and urban health centers. Given the lack of physicians and more highly trained personnel, I expected to find staff members who were inadequately prepared for their responsibilities. However, I found the staff to be well trained and



competent in their practice. The greater issue was the lack of funding for them to return to school for further training. In private rural health centers such as this, salaries are dependent on the volume of patients seen. In government health centers, there is a guaranteed monthly stipend which means greater financial security for employees. This makes staff retention problematic at the rural level. Job satisfaction suffers because nurses work overtime but do not receive adequate compensation.

*Charge Nurse Hellen Adengo and the author at
Buchanagandi Health Center*

What I Discovered about Nursing

The main obstacle to healthcare delivery in rural Uganda is resource distribution and management. I expected to see a general lack of supplies and equipment, but the unit was on the receiving end of multiple international NGOs' efforts to pass on medical supplies. Unfortunately, donated items were often expired, not labeled in English, or mismatched with the needs of the health center. For example, a delivery bed was donated that did not fit through the doorway since no one had checked the bed's size and the doors ahead of time. The staff was considering tearing down a wall to get the bed inside. This lack of assessment of the

perceived and actual needs of rural centers struck me as a missing link in the chain of philanthropy and resource management.

There are success stories mixed in as well. Uganda's implementation of the World Health Organization's initiative promoting country-wide administration of childhood vaccines is one example of well planned resource distribution. One trained healthcare worker and I spent every Thursday riding our bicycles deep into the country with an ice box full of vaccines. We went to different villages and spread the word that we were available to administer certain vaccines, such as measles, tetanus, or polio. Villagers did not fear the vaccines, they seemed quite eager to receive them. But the children were petrified of me; many in the rural villages had never seen a white person before. Nevertheless, women and children got in line with their immunization cards, and we vaccinated whole villages—one person at a time.

In addition to vaccinations, the rural nurses are in charge of assessing and diagnosing patients and prescribing treatment. This is quite different from the role of an American nurse, who does not diagnose patients, prescribe treatment, or have a high level of administrative responsibility. Without adequate numbers of physicians working rurally in Uganda, nurses have to step into the role of a primary care provider. Each morning Ugandan nurses evaluate their patients and request further laboratory "investigations," as they call blood work. In between patients, they do inventory, stock the facility, and make sure that the health center is compliant with government and district standards.



Women bring their children for vaccine administration

Regardless of these demands, I found the staff to be compassionate, efficient, and willing. At the same time, I found them to be overworked, underpaid, and often unable to spend time teaching patients concepts like disease prevention and health promotion. Optimally, nurses would discuss with patients lifestyle issues, such as balanced nutrition, personal hygiene, and family planning. This could help prevent illness and complications in the future and be instrumental in changing the community's attitudes toward healthcare from reactive to proactive. The health center could become a place where people work to stay healthy instead of where they come for a cure to a previously contracted disease.

Another issue vital to the improvement of the population's health is the influence of educated health workers at the rural level. Uganda is a tribal country made up of peoples who are growing farther and farther apart, leading to the violent conflicts that make news headlines. This growing separation is partly caused by the disparity between urban life and village life. Concentrated in the cities are people who speak English and are well educated, employed, and considerably more financially secure. As the cities become more influenced by the Western world, this gap signifies more than just rich versus poor; the dress, lifestyle, pace, and language of the city dweller all alienate the villager. The country is divided between those who strive to provide the Western urban environment for their children and those who seek to maintain tribal culture and identities.

I was exposed to this division on a daily basis in the healthcare setting. People arrived from villages having seen the local healers and having used herbal remedies. Others would refuse treatment, refuse to be admitted, or refuse to be transferred to the regional city hospital. Multiple women refused to deliver babies at

the center, preferring to deliver at home with their female relatives as attendants. Their refusals were based on lack of finances, their culture and traditions, and family influence.

I found myself frustrated that I was unable to provide care where it was most needed. I spent much of my time trying to understand the balance between Western medicine and local remedies, and how to best approach these situations. At times I was able to have someone translate my intentions and, occasionally, that persuaded the sick person to accept treatment. Other times, regardless of my explanation and reasoning, I would watch someone die after they refused treatment. I anticipated this exposure to death, but I never got used to the postmortem duties and responsibilities. I would wrap the body of the deceased in a sheet and the family would carry the body home, sometimes balanced on the back of a bicycle. People would stare, wail, congregate, and pray. Most of the time I would excuse myself, retreat to the staff quarters and watch out a window, trying to comprehend the way death affects people and how grief is such a personal experience.

Whether rural or urban, private or governmental, I discovered that the role of the Ugandan nurse is defined by the resources available: her healthcare team, her education, and her ability to step up to the challenges that call for someone, anyone, to help. The most striking aspect of the rural Ugandan nurse is the selfless approach to patient care which focuses on treating the patient without regard to expertise, resources, risk, or the patient's ability to pay. This understanding of nursing and what it means to serve others has affected my perception of nursing and of what type of nurse I would like to become.

Culture Clash

While the number of deaths and preventable diseases was somewhat unexpected and entirely devastating to see, the most difficult experience for me was the reality of the role women play in tribal society. Uganda has a patriarchal society where polygamy is a way of life for approximately 35% of the population. Polygamy is practiced by people from all the main religions found in Uganda: Catholic, Muslim, and Protestant. Women kneel to greet men. Women are expected to lower their voices, only speak when spoken to, and sometimes even to sit at a lower level than men. I met female university students who, despite their progressive educational position, told me that they would have to marry "right" when they graduate. This is necessary, they said, because they "need a man to make decisions for them because men have better problem solving skills and are born smarter with larger brains." Some women expressed frustration at this way of life, but when a man came around, they too were on their knees suffering silently. They said that things are changing slowly but will never really change.

I didn't know how to react in these situations. I expected that conversations would be a cultural exchange, meaning that I teach them about my country and culture and they teach me about theirs. But there was no room for discussion; I felt compelled to tell them I fundamentally disagreed with their belief system. These views at times limited my relationships with women because I could not identify with their understanding of their culture and their attitude that things would never change.



Host mother, Margaret Medeyi, and the author in customary gomesi

Being a white person and a guest, I was exempt from some of the cultural expectations, but men occasionally asked me to “fetch” things or assumed that I had no opinions in discussions. On several occasions I almost lost my cultural—understanding—cool. The mere tone men used with women was sometimes enough to cause me to excuse myself from the conversation. This male–female relationship was not common in the healthcare setting and did not affect a female nurse’s ability to care for a male patient, but in the village and the home it was a part of my experience that I could not have prepared for.

But what can a trip from the Western world to a developing African nation promise if not a struggle with cultural understanding? Since returning to the US, I have continued to evaluate my responses to different cultural beliefs and healthcare practices. I always end up at the same place: Africa is not so different and far away. Right here in the United States there are millions of people wandering around who have opposing beliefs about the way this world works. Spending time with people who challenged my beliefs has only made me stronger and more confident in what I do believe and has led me to re–examine some of my own perspectives as well. It is easy to be ethnocentric and assume that my understanding is superior. Learning that some people are happy in a world that I would find unbearable was a monumental lesson in humility and acceptance.

Reality Check

Over ten weeks, I also learned a lot about how politics affect life and health care at a systems level. This spiked my interest in responsible philanthropy and the need for community assessments and development plans, which may very well be where my professional career is heading. My research conclusions about the widening



With host parents Denis and Margaret Medeyi at the home in Bulangira village

gap between urban and rural health centers and health professionals may become the basis for further research. The evidence supports a need for educated health workers at all levels, adequate financial benefits, and the opportunity to return for further training. As the healthcare needs and global initiatives change, so must the capabilities of the local staff. Further research is needed along with the implementation of continuing education programs, financial support, and informed resource management.

In addition to the clinical and research skills I learned, my time in Uganda was emotionally and spiritually satisfying because I was challenged in ways that are rare for American, middle class, collegiate females. I ignored my

taste buds to try goat meat, acclimated to gross professional differences, and lost some creature comforts by using pit latrines, avoiding cockroaches and rats, and getting used to not showering or having electricity. These obvious difficulties paled in comparison to the confidence I developed, the people I met, the relationships I made, and the self–assurance I gained that wherever I go professionally or personally, I will be successful.

By Western standards, the life of a Ugandan can seem bleak and spent simply trying to survive. In some ways, that is true. But I was fortunate to see the moments when people laugh and families grow and people enjoy life at a very natural level, untouched by the fast–paced, stress–inducing place where I live. It was a reality check in the least subtle way possible, and a glaring reminder that there is no reason at all not to take advantage of every opportunity available.

I would like to thank all of those who made my experience possible: IROP benefactors Dana Hamel and Frank R. and Patricia Noonan; the Hamel Center for Undergraduate Research, including Donna Brown, Georgeann Murphy, and Peter Akerman; Gene Harkless, my UNH nursing mentor, and Denis Medeyi, my Ugandan mentor; the staff of All Saints Buchanagandi Health Center; and the Medeyi Family and Barocho clan for hosting me in their country. I also wish to thank my friends and family for taking an interest in my experience and supporting my re-assimilation as well as plans to return to Uganda after graduation.

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Author Bio

*A native of El Segundo, California, senior **Emily Roberts** has two passions: nursing and traveling. Crossing the country to attend the University of New Hampshire was only the first step for this dual nursing and international affairs major. Since beginning her collegiate career, Emily has constantly searched for new ways to satisfy her interests. Over the winter of 2006, Emily traveled to Guatemala with the Department of Nursing, and in the summer of 2006, she participated in a student volunteer group that worked in the Dominican Republic. Through a fellow volunteer's professor, Emily made contact with a family from Uganda, and a new adventure was set into motion. After receiving a grant from the International Research Opportunities Program (IROP), Emily left UNH for Uganda in May 2007 to research the role of the nurse. She had no idea that during her ten-week stay she would spend her days not just researching Ugandan nurses but actually becoming one.*

After graduating in May 2008 with a B.S. in nursing, Emily plans to continue her world travels. She has already made arrangements to return to Uganda this fall to visit the host family she stayed with in 2007 and to work in the health center where she conducted her research. Eventually, Emily hopes to get a PhD in the nursing field, but until then she is enjoying her travels and the new perspectives they give her on what it means to be a nurse.

Mentor Bio

***Gene Harkless**, DNSC, ARNP, is an associate professor in the Department of Nursing. She is a family nurse practitioner who has taught at the University of New Hampshire since 1985, focusing her research on evidence-based practice and clinical decision making. Mentoring IROP students is one of her scholarly passions and helps enrich her own international work in Norway and Ghana.*

Dr. Harkless is keen to spread the word about the power of the undergraduate international research experience. "For past IROPers, it has been life-changing. They create a whole new lens through which to see the world. In fact, it may be more like a kaleidoscope—their world views take on texture and complexity that begets new questions," Harkless says. "Students such as Emily are treasures. Emily came to UNH after a year's immersion in France and knew from day one that she was going to complete a dual major in international affairs and nursing, even though no one had ever done this. Going to Uganda gave Emily the opportunity to challenge herself both academically and personally. Not only did she conduct her study of nurses' triage work in rural Uganda, she lived in a small village in which the local language is not familiar and

where women hold a different status from our Western expectations. Now that is an adventure. Amazing. As for me, I get to work with brave and smart students like Emily and watch the alchemy create a budding scholar."